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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00147903. The 2567 was sent electronically to the facility on 02/04/2020.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications.	F 636		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 33 residents. The sample included 15 residents. Based on interviews and record reviews, the facility failed to analyze the "Care Area Assessments" (CAAs) to provide a rationale for care plan development for Resident (R)17.

Findings included:

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- The "Significant Change Minimum Data Set" (MDS) dated 12/11/19 for R17 documented triggered CAAs for "Cognitive Loss/Dementia", "ADL Functional/Rehabilitation Potential", "Urinary Incontinence and Indwelling Catheter". "Mood State", "Falls", Pressure Ulcer", and Psychotropic Drug Use"

Review of the triggered CAAs revealed a lack of "Analysis of Findings" documentation.

The "Resident Assessment Instrument" (RAI-the instructive guide for completion of the MDS) manual requirements state the CAAs are completed no later than 14 calendar days after the determination of the significant change in the resident's status

On 01/22/20 at 08:43 AM Administrative Nurse D stated he and the MDS coordinator complete the MDS assessments as directed by the "Resident Assessment Instrument" (RAI) manual.

On 01/22/20 at 08:47 AM Administrative Nurse E stated CAAs are completed no later than 14 days with every comprehensive MDS assessment. The completed MDS assessments are sent to the Director of Nursing for review and transmission.

The facility's undated "MDS" policy documented the facility conducts a comprehensive MDS assessment according to Federal regulations and Medicare guidelines. A Registered Nurse reviews and completes the assessments when done by a licensed nurse. The facility staff follow the current RAI manual for completion of the MDS.

The facility failed to analyze the CAAs to provide

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F 636	Continued From page 3 a rationale for care plan development, which had the potential of ineffective identification of R17's strengths, goals, preferences, and care needs.	F 636		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility identified a census of 33 residents. The sample included 15 residents. Based on record reviews and interviews the facility failed to complete accurate Minimum Data Set (MDS) assessments for five Residents (R)15, R17, R21, R29, R2, and R31 in the sample. Findings included: R15's "Admission Minimum Data Set" (MDS) dated 11/28/19 documented she received an anticoagulant (medications which inhibit the coagulation of the blood) seven of the seven days in the look back period. The "Physician's Order" tab of R15's "Electronic Medical Record" (EMR) documented an order for aspirin (a nonsteroidal anti-inflammatory medication which prevents blood cells from clumping together to form a clot) 81 milligrams (mgs.) daily for cerebral infarction (an area of necrotic tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain) dated 11/16/19. R17's "Significant Change MDS" dated 12/11/19 documented she received an anticoagulant seven	F 641		

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of the seven day look back period.

The POS tab of the EMR for R17 documented an order for Plavix (a medication which prevents platelets from clumping together and forming blood clots) 75 mgs. daily for cerebral infarction dated 11/07/19.

R21's "Annual MDS" dated 12/19/19 documented she received an anticoagulant seven of the seven days in the look back period.

The "Physician's Order" tab of R21's EMR documented an order for aspirin 81 mgs. daily for prophylaxis (preventing the spread of disease/medical conditions) dated 11/08/18.

R29's "Quarterly MDS" dated 01/01/20 documented she received an anticoagulant seven of the seven days in the look back period.

The "Physician's Order" tab of R29's EMR documented an order for aspirin 81 mgs. daily for prophylaxis dated 07/24/19.

R2's "Quarterly MDS" dated 01/10/20 documented she received Plavix five of the seven days in the look back period.

R2's "POS" tab of the EMR documented an order for Plavix 75 mgs. daily for coronary artery disease (abnormal condition that may affect the flow of oxygen to the heart) dated 05/17/19.

R31's "Admission MDS" documented she received no anticoagulants in the look back period.

The "Physician's Order" tab of R31's EMR

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F 641	Continued From page 5 documented an order for Xarelto (an anticoagulant medication) 10 mgs. daily for blood clot prevention from 01/01/20 until 01/17/20. R31's "Medication Administration Record" documented administration of Xarelto on 1/1/20, 1/2/20, 1/3/20, 1/4/20, 1/5/20, and 1/6/20. On 01/22/20 at 08:43 AM Administrative Nurse D stated he and the MDS coordinator completed the MDS assessments as directed by the "Resident Assessment Instrument" (RAI) manual. Aspirin and Plavix are not anticoagulants. He verified R31 received an anticoagulant. On 01/22/20 at 08:47 AM Administrative Nurse E stated she completed the MDS assessments and the Director of Nursing reviewed and transmitted them. She looked up medication classifications when she was unsure of their use. The facility's undated "MDS" policy documented the facility conducts a comprehensive MDS assessment according to Federal regulations and Medicare guidelines. A Registered Nurse reviews and completes the assessments when done by a licensed nurse. The facility staff follow the current RAI manual for completion of the MDS. The facility failed to complete accurate Minimum Data Set (MDS) assessments which had the potential of ineffective identification of her care plan needs.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		

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be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 33 residents. The sample included 15 residents. Based on record reviews, observations, and interviews the facility failed to revise the comprehensive care plan to include changes in weight status and antihypertensive (medications used to treat hypertension-elevated blood pressure) medications for Resident (R)16 of five residents sampled for unnecessary medication use.

Findings included:

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- The "Diagnoses" tab of R16s "Electronic Medical Record" (EMR) documented diagnoses of hypertension elevated blood pressure), dementia (progressive mental disorder characterized by failing memory, confusion), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and major depressive disorder (major mood disorder).

The "Admission Minimum Data Set" (MDS) dated 06/13/19 documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. She required extensive staff assistance with her "Activities of Daily Living" (ADLs), with supervision and set up assistance for eating.

The "Quarterly MDS" dated 12/23/19 documented R16 had severely impaired cognition. She required extensive staff assistance with her "Activities of Daily Living" (ADLs), with supervision and set up assistance for eating. She had no or unknown weight loss

The "Cognitive Loss/Dementia Care Area Assessment" dated 06/14/19 documented R16 had periods of disorganized thoughts and inattention. She could not always engage in meaningful conversation, set goals, or make her own decisions.
.
The "Nutritional Care Plan" revised on 10/10/19 documented R16 was at an increased risk for unintentional weight loss due to her dementia. She left the dining table at times but, usually had a good intake. She had a slight weight loss since admitting. She had a risk of weight fluctuations due to edema. The care plan lacked documentation of 12.37% weight loss in seven

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months.

The EMR lacked a care plan for hypertension and the medication changes made to decrease her blood pressure.

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The "Physician's Order" tab of R16's EMR documented an order for clonidine (medication used to treat hypertension) 0.1 milligram every 12 hours as needed for a systolic blood pressure (amount of pressure in the arteries during the contraction of heart) was greater than 170 mmHg (millimeters of Mercury) dated 08/20/19.

Review of R16's EMR 08/21/19 through 12/28/19 documented systolic blood pressures above 170 three days in August, nine days in September, 10 days in October, one day in November, and two days in December. The EMR lacked documentation for Clonidine given for those instances.

Review of the "Weight" tab in the EMR revealed R16 weighed 215 pounds (lbs.) on 06/06/19 and 188 lbs. on 01/12/20 for a 12.37% weight loss in seven months.

On 01/16/20 at 11:54 AM R16 pushed her lunch plate toward her table mate. She was served a sandwich at 12:32 PM looked at the sandwich and dropped it on the table.

On 01/22/20 at 11:29 AM Licensed Nurse (LN) G stated initial care plans are documented by the nursing staff. Revisions to the care plan are usually done by the MDS coordinator but, nurses can do the revisions,

On 01/22/20 at 02:00 PM Administrative Nurse E

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F 657	Continued From page 9 stated she usually completed revisions of care plans but, the nurses can complete them. Information for revisions is gathered from new physician orders and information from nursing staff. On 01/22/20 at 02:05 PM Administrative Staff E stated the Director of Nursing and the MDS coordinator document care plan revisions. The facility's undated "Comprehensive Care Plan" policy documented the comprehensive care plans were reviewed and revised as needed by the interdisciplinary team at least quarterly and with any changes in the resident's status. The care plans are individualized and reflect the physical and psychosocial issues or concerns and interventions for the resident. The facility failed to revise the comprehensive care plan to include changes in weight status and antihypertensive medications for R16, which had the potential for increased weight loss and an increase in blood pressure, which could lead to nutritional deficits and unwarranted side effects from hypertension.	F 657		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		

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irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 33 residents. The sample included five residents for medication review. Based on observations, record reviews, and interviews the facility failed to ensure the Consultant Pharmacist (CP) identified the facility's failure to notify the physician of vital signs outside physician parameters for Resident (R) 29, R5, and R16. The facility also failed to ensure the CP identified medications not administered as

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ordered by the physician for R29 and R16.

Findings included:

- The "Electronic Medical Record" (EMR) for R29 included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (high blood pressure), and heart failure.

The "Admission Minimum Data Set" (MDS) dated 07/05/19 documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. R29 required one person staff assistance with Activities of Daily Living (ADLs).

The "Quarterly MDS" dated 01/01/2020 for R29 documented no change from the admission assessment.

The "Care Area Assessment" (CAA) for "Cognition" dated 01/01/2020 documented that R29 had severe cognitive impairment.

The "Medications" care plan dated 1/09/2020 documented R29 took multiple medications and was at risk for side effects. R29 took metoprolol (medication used for hypertension) and MS Contin (medication used for pain).

The EMR revealed an order dated 08/22/2019 for metoprolol tartrate 25 milligrams (mgs.) one half tablet by mouth two times per day for hypertension. Hold for systolic blood pressure (the amount of pressure in the arteries during the contraction of the heart muscle) less than 100 or heart rate less than 60 and notify the physician.

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The EMR revealed an order dated 12/30/19 for MS Contin Extended Release tablet 15 mgs. by mouth two times per day for pain management.

Review of the MAR tab of the EMR from 08/01/2019 to 01/16/2020 for R29 revealed lack of documentation the physician was notified, or metoprolol was held as ordered by the physician when out of parameters for seven of 62 shifts in December 2019 and two of 62 shifts in January 2020.

Review of the MAR tab of the EMR also revealed lack of documentation that MS Contin was administered for three of 62 shifts in December 2019, seven of 60 shifts in November 2019, seven of 62 shifts in October 2019, and one of 60 shifts in September 2019.

The CP's monthly medication review for R29 was reviewed from July 2019 to January 17, 2020. The record lacked documentation that the CP identified and notified the facility about medication administered outside of parameters, or medication not administered as ordered by the physician.

On 01/21/20 at 04:32 PM R29 sat in a chair in the dining room. Her walker was by her side. She sat upright in the chair. She was alert and greeted her sister when she sat beside her. R29 showed no non-verbal signs of distress.

On 01/22/20 at 12:51 PM R29 walked slowly and steadily down the hall to her room. R29 smiled and greeted a staff member she passed in the hall. R29 showed no non-verbal signs of distress.

On 01/22/20 at 09:58 AM Certified Medication

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Aide (CMA) R stated most medications had parameters. When the parameters were exceeded, the medication was held and reported to the nurse. The nurses documented after he/she looked into the situation.

On 01/22/20 at 11:29 AM Licensed Nurse (LN) G stated the CMAs reported to the nurses if blood pressures or pulses were outside parameters. The nurses rechecked them and followed the orders.

On 01/22/20 at 2:45 PM LN H stated blanks in the MAR meant the medication was not given. She reviewed the MAR from December 24, 2019 and confirmed the MS Contin was not given on the evening shift.

On 01/22/20 at 11:48 AM Administrative Nurse D stated the CMA notified the nurses that blood pressures or pulses were outside parameters. The nurse rechecked the blood pressure and/or pulse and notified the physician. The events were documented. He stated blanks in the MAR meant the medication was not administered.

On 01/22/20 at 02:03 PM CP GG stated she visited the facility monthly for medication review. She stated she reviewed medication orders, blood pressure and pulse parameters, and medication administration.

The facility policy "Medication Monitoring / Medication Regimen Review" dated March 2011 documented the CP reviewed the medication regimen of each resident at least monthly. The resident's response to drug treatment was evaluated to determine if therapeutic goals were achieved. The undated "Blood Pressure" policy

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did not address guidelines for parameters.

The facility failed to ensure the CP identified and reported the metoprolol was given when R29's pulses were outside of the physician ordered parameters and failed to ensure the CP identified the physician was not notified. The CP also failed to identify and report the MS Contin was not administered as ordered by the physician. This had the potential for unnecessary medication administration, thus leading to possible harmful side effects.

- The "Diagnoses" tab of R5's "Electronic Medical Record" (EMR) documented diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), atrial fibrillation (rapid, irregular heart beat), and hypertension (elevated blood pressure).

The "Annual Minimum Data Set" (MDS) dated 07/29/19 documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. He required supervision to extensive staff assistance with his "Activities of Daily Living" (ADLs).

The "Quarterly MDS" dated 10/27/19 documented a BIMS score of 15, which indicated intact cognition. He required limited to extensive staff assistance with his ADLs.

The "ADL" Care Area Assessment dated 07/31/19 documented R5 required supervision to extensive staff assistance with his ADLs.

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The "Hypertension" care plan dated 08/21/19 documented the facility staff administered antihypertensive (used to treat hypertension) medications as ordered by the physician.

The "Physician's Order" tab in R5's EMR documented an order for metoprolol 25 milligrams daily for hypertension and hold the medication if the systolic blood pressure (amount of pressure in the arteries during the contraction of heart) was under 110 (mmHg-millimeters of Mercury) or the pulse was under 60 beats per minute, dated 08/22/19.

Review of the "Medication Administration Record" (MAR) in R5's EMR from 08/22/19 through 01/21/20 documented metoprolol was given with pulses less than physician ordered parameters on one day in September and three days in December. The MAR lacked documentation of blood pressure or pulse readings and metoprolol was given on January third through January 21. The EMR lacked documentation for physician notification

The CP's "Monthly Medication Review" reviewed April 2019 through December 2019 lacked documentation for the metoprolol given outside of physician ordered parameters.

On 01/22/20 at 09:58 AM Certified Medication Aide (CMA) R stated CMAs held blood pressure medications when the blood pressures and pulses are outside of physician ordered parameters and notified the nurses.

On 01/22/20 at 11:29 AM Licensed Nurse (LN) G stated the CMAs contact the nurses with blood pressures and pulses outside of the physician

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ordered parameters. The nurses recheck the blood pressures and pulses and notify the physician for follow up orders and document in the EMR.

On 01/22/20 at 11:48 AM Administrative Nurse D stated he expected CMAs to hold anti-hypertensive medications when blood pressures or pulses were outside of physician ordered parameters and notify the nursing staff. He expected nurses to recheck the blood pressures and pulses, notify the physician and document the discussion.

On 01/22/20 at 09:45 AM R5 sat in his room, watching television. He denied pain. He stated he didn't like the loss of independence he has suffered due to his Parkinson's disease diagnosis but, is learning to live with it.

On 01/22/20 at 02:00 PM CP GG stated he checked on blood pressure and pulse parameter monitoring with the MMRs.

The facility's "Medication Regimen Review" policy dated March 2011 documented the MRR activities included but, are not limited to, evaluating medication orders to determine the residents' orders represent optimal therapy for the individual. The resident's response to the medication treatment is evaluated through the use of the MAR and other data to determine if therapeutic goals are achieved.

The facility failed to ensure the CP monitored the administration of R5's metoprolol when his pulse was outside of physician ordered parameters. And also failed to monitor blood pressures and pulses in January first through January 21. This

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had the potential for unnecessary medication administration and unwarranted side effects.

- The "Diagnoses" tab of R16s "Electronic Medical Record" (EMR) documented diagnoses of hypertension (elevated blood pressure), dementia (progressive mental disorder characterized by failing memory, confusion), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and major depressive disorder (major mood disorder).

The "Admission Minimum Data Set" (MDS) dated 06/13/19 documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. She required extensive staff assistance with her "Activities of Daily Living" (ADLs), with supervision and set up assistance for eating.

The "Quarterly MDS" dated 12/23/19 documented R16 had severely impaired cognition. She required extensive staff assistance with her "Activities of Daily Living" (ADLs), with supervision and set up assistance for eating.

The "Cognitive Loss/Dementia" Care Area Assessment dated 06/14/19 documented R16 had periods of disorganized thoughts and inattention. She could not always engage in meaningful conversation, set goals, or make her own decisions.

The "Dementia" care plan dated 06/11/19 documented R16 had impaired cognitive function with impaired thought processes related to her dementia diagnosis. She had difficulty making decisions.

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The "Physician's Order" tab of R16's EMR documented an order for clonidine (medication used to treat hypertension) 0.1 milligram every 12 hours as needed for a systolic blood pressure (amount of pressure in the arteries during the contraction of heart) was greater than 170 mmHg (millimeters of Mercury) dated 08/20/19.

Review of R16's EMR 08/21/19 through 12/28/19 documented systolic blood pressures above 170 three days in August, nine days in September, 10 days in October, one day in November, and two days in December. The EMR lacked documentation for Clonidine given for those instances.

The CP's "Monthly Medication Review" (MMR), reviewed from June 2019 through December 2019, did not address the facility's failure to administer the clonidine when the systolic blood pressures were greater than 170 mmHg. The EMR lacked documentation of notification to the physician.

On 01/16/20 at 09:34 AM R16 sat at the community activity table and held a baby doll.

On 01/22/20 at 11:29 AM Licensed Nurse (LN) G stated the CMAs contact the nurses with elevated blood pressures. The nurses recheck the blood pressure, give the ordered clonidine, notify the physician, and document in the EMR.

On 01/22/20 at 11:48 AM Administrative Nurse D stated he expected the nurses to recheck the blood pressures, give the clonidine as ordered, notify the physician, and document the discussion.

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F 756	Continued From page 19 On 01/22/20 at 02:00 PM CP GG stated he checked the residents' MARS to verify orders such as clonidine were administered as ordered by the physician. The facility's "Medication Regimen Review" policy dated March 2011 documented the MRR activities included but, are not limited to, evaluating medication orders to determine the residents' orders represent optimal therapy for the individual. The resident's response to the medication treatment is evaluated through the use of the MAR and other data to determine if therapeutic goals are achieved. The facility failed to ensure the CP monitored the administration of physician ordered clonidine for R16's elevated blood pressures. This had the potential for unwarranted complications from high blood pressure.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		

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§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 33 residents. The sample included five residents for medication review. Based on observations, record review, and interview the facility failed to notify the physician of vital signs outside physician parameters and failed to ensure medications were given when blood pressures and pulses were outside of physician parameters for Resident (R) 29, R5, and R16. The facility also failed to ensure medications were administered as ordered by the physician for R29 and R16.

Findings included:

- The "Electronic Medical Record" (EMR) for R29 included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (high blood pressure), and heart failure.

The "Admission Minimum Data Set" (MDS) dated 07/05/19 documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. R29 required one person staff assistance with Activities of Daily Living (ADLs).

The "Quarterly MDS" dated 01/01/2020 for R29 documented no change from the admission

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assessment.

The "Care Area Assessment" (CAA) for "Cognition" dated 01/01/2020 documented that R29 had severe cognitive impairment.

The "Medications Care Plan" dated 1/09/2020 documented R29 took multiple medications and was at risk for side effects. R29 took metoprolol (medication used for hypertension) and MS Contin (medication used for pain).

The EMR revealed an order dated 08/22/2019 for metoprolol tartrate 25 milligrams (mgs.) one half tablet two times per day for hypertension. Hold for systolic blood pressure (the amount of pressure in the arteries during contraction of the heart muscle) less than 100 or heart rate less than 60 and notify the physician.

The EMR revealed an order dated 12/30/19 for MS Contin Extended Release tablet 15 mgs. two times per day for pain management.

Review of the MAR tab of the EMR from 08/01/2019 to 01/16/2020 for R29 revealed lack of documentation the physician was notified, or metoprolol was held as ordered by the physician when blood pressure and/or heartrate were out of parameters for seven of 62 shifts in December 2019 and two of 62 shifts in January 2020.

Review of the MAR tab of the EMR also revealed lack of documentation that MS Contin was administered for three of 62 shifts in December 2019, seven of 60 shifts in November 2019, seven of 62 shifts in October 2019, and one of 60 shifts in September 2019.

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On 01/21/20 at 04:32 PM R29 sat in a chair in the dining room. Her walker was by her side. She sat upright in the chair. She was alert and greeted her sister when she sat beside her. R29 showed no non-verbal signs of distress.

On 01/22/20 at 12:51 PM R29 walked slowly and steadily down the hall to her room. R29 smiled and greeted a staff member she passed in the hall. R29 showed no non-verbal signs of distress.

On 01/22/20 at 09:58 AM Certified Medication Aide (CMA) R stated most medications had parameters. When parameters were exceeded, the medication was held and reported to the nurse. The nurses documented after he/she looked into the situation.

On 01/22/20 at 11:29 AM Licensed Nurse (LN) G stated the CMAs reported to the nurses if blood pressures or pulses were outside parameters. The nurses rechecked them and followed the orders.

On 01/22/20 at 2:45 PM LN H stated blanks in the MAR meant the medication was not given. She reviewed the MAR from December 24, 2019 and confirmed MS Contin was not given on the evening shift.

On 01/22/20 at 11:48 AM Administrative Nurse D stated the CMA notified the nurses that blood pressures or pulses were outside parameters. The nurse rechecked the blood pressure and/or pulse and notified the physician. The events were documented. He stated blanks in the MAR meant the medication was not administered.

The undated facility "Blood Pressure Policy" did

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not address guidelines for parameters.

The facility failed to hold the metoprolol when R29's pulses were outside of the physician ordered parameters and failed to notify the physician that the medication was held. The facility also failed to ensure that MS Contin was administered as ordered by the physician. This had the potential for unnecessary medication administration, thus leading to possible harmful side effects.

- The "Diagnoses" tab of R5's "Electronic Medical Record" (EMR) documented diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), atrial fibrillation (rapid, irregular heart beat), and hypertension (elevated blood pressure).

The "Annual Minimum Data Set" (MDS) dated 07/29/19 documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. He required supervision to extensive staff assistance with his "Activities of Daily Living" (ADLs).

The "Quarterly MDS" dated 10/27/19 documented a BIMS score of 15, which indicated intact cognition. He required limited to extensive staff assistance with his ADLs.

The "ADL" Care Area Assessment dated 07/31/19 documented R5 required supervision to extensive staff assistance with his ADLs.

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The "Hypertension" care plan dated 08/21/19 documented the facility staff administered antihypertensive (used to treat hypertension) medications as ordered by the physician.

The "Physician's Order" tab in R5's EMR documented an order for metoprolol 25 milligrams daily for hypertension and hold the medication if the systolic blood pressure (amount of pressure in the arteries during the contraction of heart) was under 110 (mmHg-millimeters of Mercury) or the pulse was under 60 beats per minute, dated 08/22/19.

Review of the "Medication Administration Record" (MAR) in R5's EMR from 08/22/19 through 01/21/20 documented metoprolol was given with pulses less than physician ordered parameters on one day in September and three days in December. The MAR lacked documentation of blood pressure or pulse readings and metoprolol was given on January third through January 21. The EMR lacked documentation for physician notification

The CP's "Monthly Medication Review" reviewed April 2019 through December 2019 lacked documentation for the Metoprolol given outside of physician ordered parameters.

On 01/22/20 at 09:58 AM Certified Medication Aide (CMA) R stated CMAs held blood pressure medications when the blood pressures and pulses are outside of physician ordered parameters and notified the nurses.

On 01/22/20 at 11:29 AM Licensed Nurse (LN) G stated the CMAs contact the nurses with blood pressures and pulses outside of the physician

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ordered parameters. The nurses recheck the blood pressures and pulses and notify the physician for follow up orders and document in the EMR.

On 01/22/20 at 11:48 AM Administrative Nurse D stated he expected CMAs to hold anti-hypertensive medications when blood pressures or pulses were outside of physician ordered parameters and notify the nursing staff. He expected nurses to recheck the blood pressures and pulses, notify the physician and document the discussion.

On 01/22/20 at 09:45 AM R5 sat in his room, watching television. He denied pain. He stated he didn't like the loss of independence he has suffered due to his Parkinson's disease diagnosis but, is learning to live with it.

On 01/22/20 at 02:00 PM CP GG stated he checked on blood pressure and pulse parameter monitoring with the MMRs.

The facility's "Medication Regimen Review" policy dated March 2011 documented the MRR activities included but, are not limited to, evaluating medication orders to determine the residents' orders represent optimal therapy for the individual. The resident's response to the medication treatment is evaluated through the use of the MAR and other data to determine if therapeutic goals are achieved.

The facility failed to hold R5's metoprolol when his pulse was outside of physician ordered parameters. The facility also failed to monitor blood pressures and pulses in January first through January 21. This had the potential for

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unnecessary medication administration and unwarranted side effects.

- The "Diagnoses" tab of R16s "Electronic Medical Record" (EMR) documented diagnoses of hypertension (elevated blood pressure), dementia (progressive mental disorder characterized by failing memory, confusion), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and major depressive disorder (major mood disorder).

The "Admission Minimum Data Set" (MDS) dated 06/13/19 documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. She required extensive staff assistance with her "Activities of Daily Living" (ADLs), with supervision and set up assistance for eating.

The "Quarterly MDS" dated 12/23/19 documented R16 had severely impaired cognition. She required extensive staff assistance with her "Activities of Daily Living" (ADLs), with supervision and set up assistance for eating.

The "Cognitive Loss/Dementia" Care Area Assessment dated 06/14/19 documented R16 had periods of disorganized thoughts and inattention. She could not always engage in meaningful conversation, set goals, or make her own decisions.

The "Dementia" care plan dated 06/11/19 documented R16 had impaired cognitive function with impaired thought processes related to her dementia diagnosis. She had difficulty making

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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decisions.
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The "Physician's Order" tab of R16's EMR documented an order for clonidine (medication used to treat hypertension) 0.1 milligram every 12 hours as needed for a systolic blood pressure (amount of pressure in the arteries during the contraction of heart) was greater than 170 mmHg (millimeters of Mercury) dated 08/20/19.

Review of R16's EMR 08/21/19 through 12/28/19 documented systolic blood pressures above 170 three days in August, nine days in September, 10 days in October, one day in November, and two days in December. The EMR lacked documentation for Clonidine given for those instances.

The CP's "Monthly Medication Review" (MMR), reviewed from June 2019 through December 2019, did not address the facility's failure to administer the clonidine when the systolic blood pressures were greater than 170 mmHg. The EMR lacked documentation of notification to the physician.

On 01/16/20 at 09:34 AM R16 sat at the community activity table and held a baby doll.

On 01/22/20 at 11:29 AM Licensed Nurse (LN) G stated the CMAs contact the nurses with elevated blood pressures. The nurses recheck the blood pressure, give the ordered clonidine, notify the physician, and document in the EMR.

On 01/22/20 at 11:48 AM Administrative Nurse D stated he expected the nurses to recheck the blood pressures, give the clonidine as ordered, notify the physician, and document the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175536	A. BUILDING _____ B. WING _____	01/22/2020

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discussion.

On 01/22/20 at 02:00 PM CP GG stated he checked the residents' MARS to verify orders such as clonidine were administered as ordered by the physician.

The facility's "Medication Regimen Review" policy dated March 2011 documented the MRR activities included but, are not limited to, evaluating medication orders to determine the residents' orders represent optimal therapy for the individual. The resident's response to the medication treatment is evaluated through the use of the MAR and other data to determine if therapeutic goals are achieved.

The facility failed to administer physician ordered clonidine for R16's elevated blood pressures. This had the potential for unwarranted complications from high blood pressure.